



**Kentucky Reportable Disease Form**  
**Department for Public Health**  
**Division of Epidemiology and Health Planning**  
**275 East Main St., Mailstop HS1E-C**  
**Frankfort, KY 40621-0001**

Disease Name \_\_\_\_\_

**Mail Form to Local Health Department**

DEMOGRAPHIC DATA						
Patient's Last Name		First	M.I.	Date of Birth / /	Age	Gender <input type="checkbox"/> M <input type="checkbox"/> F <input type="checkbox"/> Unk
Address		City	State	Zip	County of Residence	
Phone Number	Patient ID Number		Ethnic Origin <input type="checkbox"/> His. <input type="checkbox"/> Non-His.	Race <input type="checkbox"/> W <input type="checkbox"/> B <input type="checkbox"/> A/PI <input type="checkbox"/> Am.Ind. <input type="checkbox"/> Other		
DISEASE INFORMATION						
Disease/Organism			Date of Onset / /		Date of Diagnosis / /	
List Symptoms/Comments				Highest Temperature		
				Days of Diarrhea		
Hospitalized? <input type="checkbox"/> Yes <input type="checkbox"/> No		Admission Date / /		Discharge Date / /		Died? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk
Date of Death / /						
Hospital Name:				Is Patient Pregnant? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, # wks _____		
School/Daycare Associated? <input type="checkbox"/> Yes <input type="checkbox"/> No				Outbreak Associated? <input type="checkbox"/> Yes <input type="checkbox"/> No		
Name of School/Daycare:				Food Handler? <input type="checkbox"/> Yes <input type="checkbox"/> No		
Person or Agency Completing form: Name: Agency:				Attending Physician: Name:		
Address:				Address:		
Phone:		Date of Report: / /		Phone:		
LABORATORY INFORMATION						
Date	Name or Type of Test	Name of Laboratory	Specimen Source	Results		
ADDITIONAL INFORMATION FOR SEXUALLY TRANSMITTED DISEASES ONLY						
Method of case detection: <input type="checkbox"/> Prenatal <input type="checkbox"/> Community & Screening <input type="checkbox"/> Delivery <input type="checkbox"/> Instit. Screening <input type="checkbox"/> Reactor <input type="checkbox"/> Provider Report <input type="checkbox"/> Volunteer						
Disease: <input type="checkbox"/> Syphilis		Stage <input type="checkbox"/> Primary (lesion) <input type="checkbox"/> Secondary (symptoms) <input type="checkbox"/> Early Latent <input type="checkbox"/> Late Latent <input type="checkbox"/> Congenital <input type="checkbox"/> Other		Disease: <input type="checkbox"/> Gonorrhea <input type="checkbox"/> Chlamydia <input type="checkbox"/> Chancroid		Resistance: <input type="checkbox"/> Penicillin <input type="checkbox"/> Tetracycline <input type="checkbox"/> Other _____
				Site: (Check all that apply) <input type="checkbox"/> Genital, uncomplicated <input type="checkbox"/> Ophthalmic <input type="checkbox"/> Pharyngeal <input type="checkbox"/> PID/Acute <input type="checkbox"/> Anorectal Salpingitis <input type="checkbox"/> Other _____		
Date of spec. Collection	Laboratory Name	Type of Test	Results	Treatment Date	Medication	Dose
If syphilis, was previous treatment given for this infection? <input type="checkbox"/> Yes <input type="checkbox"/> No						
If yes, give approximate date and place _____						

**902 KAR 2:020 requires health professionals to report the following diseases to the local health departments serving the jurisdiction in which the patient resides or to the Kentucky Department for Public Health (KDPH).**

(Copies of 902 KAR 2:020 available upon request)

**REPORT IMMEDIATELY by TELEPHONE to the Local Health Department or the KY Department for Public Health:**

- Unexpected pattern of cases, suspected cases or deaths which may indicate a newly recognized infectious agent
- An outbreak, epidemic, related public health hazard or act of bioterrorism, such as SMALLPOX

**Kentucky Department for Public Health in Frankfort**  
**Telephone 502-564-3418 or 1-888-9REPORT (973-7678)**  
**FAX 502-696-3803**

**REPORT WITHIN 24 HOURS**

Anthrax	Encephalitis, West Nile	Rabies, animal
Botulism	<i>Haemophilus influenzae</i>	Rabies, human
Brucellosis	invasive disease	Rubella
Campylobacteriosis	Hansen's disease	Rubella syndrome, congenital
Cholera	Hantavirus infection	Salmonellosis
Cryptosporidiosis	Hepatitis A	Shigellosis
Diphtheria	Listeriosis	Syphilis, primary, secondary,
<i>E. coli</i> O157:H7	Measles	early latent or congenital
<i>E. coli</i> shiga toxin positive	Meningococcal infections	Tetanus
Encephalitis, California group	Pertussis	Tularemia
Encephalitis, Eastern Equine	Plague	Typhoid Fever
Encephalitis, St. Louis	Poliomyelitis	<i>Vibrio parahaemolyticus</i>
Encephalitis, Venezuelan Equine	Psittacosis	<i>Vibrio vulnificus</i>
Encephalitis, Western Equine	Q Fever	Yellow Fever

**REPORT WITHIN ONE (1) BUSINESS DAY**

Foodborne outbreak	Hepatitis B, acute	Toxic Shock Syndrome
Hepatitis B infection in a	Mumps	Tuberculosis
pregnant woman or child	Streptococcal disease	Waterborne outbreak
born in or after 1992	invasive, Group A	

**REPORT WITHIN FIVE (5) BUSINESS DAYS**

⚠ AIDS	⚠ HIV infection	Rocky Mountain
Chancroid	Lead poisoning	spotted fever
<i>Chlamydia trachomatis</i>	Legionellosis	<i>Streptococcus pneumoniae</i> ,
infection	Lyme disease	drug-resistant invasive
Ehrlichiosis	Lymphogranuloma venereum	disease
Gonorrhea	Malaria	Syphilis, other than primary,
Granuloma inguinale	Rabies, post exposure	secondary, early latent or
Hepatitis C, acute	prophylaxis	congenital
Histoplasmosis		Toxoplasmosis

Influenza virus isolates are to be reported weekly by laboratories.

902 KAR 02:065 requires long term care facilities to report an outbreak (2 or more cases) of influenza-like illnesses (ILI) within 24 hours to the local health department or the KDPH.

⚠ *All cases of HIV infections/AIDS are reportable to a separate surveillance system in accordance with KRS 211.180(1)b. To obtain report forms contact the HIV/AIDS Branch at (502)-564-6539.*

**DO NOT REPORT ON THIS FORM.**

**Note: Animal bites shall be reported to local health departments within twelve (12) hours in accordance with KRS 258:065.**



## DIFFERENTIAL DIAGNOSIS OF COMMON CHILDHOOD DISEASES ASSOCIATED WITH RASH

	<b>Rubeola (Measles)</b>	<b>Rubella (German Measles)</b>	<b>Roseola</b>	<b>Fifth Disease</b>	<b>Scarlet Fever, Scarlatina</b>	<b>Varicella (Chicken Pox)</b>
Etiology	Rubeola virus	Rubella virus	Not yet identified, probably several viruses	Parvovirus	Group A Streptococcus	Varicella-zoster virus
Characteristics of rash	Severe red maculopapular, becomes confluent	Mild red maculopapular, remains discrete	Reddish bluish, "goose flesh," fades on pressure	Red (like slapped cheek), lacy and reticulated later.	Rash occurs 12hrs after high fever, pin-sized lesions soon become generalized,	Tiny clear blisters surrounded by redness, soon forms crust and scab.
Part of body on which rash first appears	Forehead, behind ears, face, neck	Forehead, cheeks, neck	Face, chest, abdomen	Upper chest, face	Intense in folds of joints; face flushed	Scalp, face, chest, abdomen
Progression of spread	Chest, abdomen, arms, legs	Chest, abdomen	Very slight spread	Lower chest, abdomen, arms	Chest, abdomen, arms, legs	Arms, legs
Progression and time intervals for diagnosis	Fever → red eyes → cough; rash at end of 2 <sup>nd</sup> or onset of 3 <sup>rd</sup> day during height of fever	1 <sup>st</sup> day: fever 2 <sup>nd</sup> day: fever and rash 3 <sup>rd</sup> day: all gone	1 <sup>st</sup> →3 <sup>rd</sup> day: fever; end of 3 <sup>rd</sup> day or onset of 4 <sup>th</sup> day: fever goes away and rash appears	Fever for 2-3 days 1 week prior to onset of rash on cheeks; 1-4 days later skin peels or flakes.	Fever on 1 <sup>st</sup> day, followed by rash; 5-7 days later skin peels or flakes	Rash and fever begin at about same time on 1 <sup>st</sup> -2 <sup>nd</sup> day; when fever stops, new blister formation stops
Severity of illness	Usually severe	Usually mild	Mild but high fever	Mild	Mild to moderate	Mild to moderate; severe in older adolescents and adults
Associated symptoms other than rash	High fever, red eyes, severe cough, mild itch	Low fever, lymph nodes, back of neck and suboccipital	Usually none	Fever mild to moderate	Exudative tonsillopharyngitis, sore, red tongue (strawberry)	Fever, mild itching
Complications	Otitis media, pneumonia, encephalitis	Usually none, occasional arthritis	Usually none	Painful joints, arthritis	Nephritis, carditis	Usually none; Reyes's Synd. possible if aspirin used to treat symptoms.
Period of infectivity	From 1 day before onset of fever to 2 days after rash appears, except in atypical cases	From 1 day before onset of fever to 1 day after rash appears	Duration of fever	For 2-3 days about 1 week prior to appearance of facial rash	From 1 day before fever or 24° after start of antibiotics or 1 week after rash appears	From 1 day before onset of fever to drying all crusts or 5 days after rash appears
Additional Information	Preventable with immunization; atypical cases frequent since advent of immunization	Preventable with immunization; virus may infect fetus; notify pregnant teachers to consult health care provider.	Does not occur after age 3-4 years	Virus may infect fetus, notify pregnant teachers to consult health care provider; not contagious once rash appears; return to school when fever ↓ and feels well.	Curable with antibiotics; complications rare but severe; return to school with health care provider note or 24° after start of antibiotics; scarlet fever/scarlatina are synonyms	Lengthy school exclusion not necessary; 3-5 days usually sufficient.

See Photos on: <http://www.immunize.org/>

## HEPATITIS CHART

	<b>Hepatitis A</b>	<b>Hepatitis B</b>	<b>Hepatitis C</b>	<b>Hepatitis D</b>	<b>Hepatitis E</b>
<b>WHAT IS IT:</b>	A virus causing inflammation of the liver, it does not lead to chronic disease.	A virus causing inflammation of the liver, it can cause liver cell damage leading to cirrhosis and cancer.	Most common bloodborne viral infection in the US; 60% to 70% develop chronic hepatitis; cirrhosis develops in 10% to 20% with chronic hepatitis C over 20-30 yrs; hepatocellular carcinoma (liver cancer) in 1% to 5%;	A virus causing inflammation of the liver, it only affect those with hepatitis B.	A virus causing inflammation of the liver, it is rare in the US and is not associated with a chronic state.
<b>INCUBATION PERIOD</b>	15 to 50 days. Average 30 days.	4 to 25 weeks. Average 8 to 12 weeks.	2 to 25 weeks, Avg 7-9 wks.	4 to 26 weeks	Avg 40 days; Range 15-60 days.
<b>HOW IS IT SPREAD?</b>	Fecal/oral route, through close person-to-person contact or ingestion of contaminated food and water.	Contact with infected blood, seminal fluid and vaginal secretions. Sex contact, contaminated needles, tattoo/body piercing and other sharp instruments. Infected mother to newborn, human bite.	Contact with infected blood, contaminated IV needles, razors, tattoo/body piercing, and other sharp instruments. Infected mother to newborn. Not easily transmitted through sex.	Contact with infected blood, contaminated needles. Sexual contact with hepatitis D infected person.	Transmitted primarily by the fecal-oral route. Fecally contaminated drinking water is the most commonly documented vehicle of transmission. Person-to-person transmission is uncommon. Nosocomial transmission, presumably by person-to-person contact, has occurred. Virtually all cases in the US have been reported among travelers returning from high HEV-endemic areas.
<b>SYMPTOMS</b>	Abdominal pain, anorexia, dark urine, fever, nausea, vomiting, diarrhea, fatigue, jaundice.	May have no symptoms. Some people have mild flu-like symptoms, dark urine, light stools, jaundice, fatigue, fever.	Same as hepatitis B	Same as hepatitis B	Similar to those of other types of viral hepatitis and include abdominal pain, anorexia, dark urine, fever, hepatomegaly, jaundice, malaise, nausea, and vomiting. Other less common symptoms include arthralgia, diarrhea, pruritus, and urticarial rash.

<b>TREATMENT OF CHRONIC ILLNESS</b>	No chronic disease.	Interferon effective in up to 45% of those treated.	A combination of alpha-interferon and ribavirin currently is the most effective.	Interferon effective with varying success.	No chronic disease.
<b>VACCINE</b>	Two doses to those of 2 years	Three doses to anyone	None	None	None
<b>WHO IS AT RISK?</b>	Household or sexual contact with an infected person or living in areas with outbreak. Travelers to developing countries, homosexual and bisexual men, IV drug users.	Infant born to infected mother, those having sex with infected person or multiple partners, IV drug users, emergency responders, healthcare workers, homosexual and bisexual men, hemodialysis patients.	Persons who ever injected illegal drugs, including those who injected once or a few times many years ago; persons who had a blood transfusion or organ transplant before July 1992; or clotting factor concentrates before 1987; hemodialysis patients; children born to HCV-positive women; healthcare workers after needle sticks, sharps or mucosal exposures to HCV-positive blood; persons with evidence of chronic liver disease.	IV drug users, homosexual and bisexual men, those who have sex with hepatitis D infected person	Most commonly recognized to occur in large outbreaks, also accounts for >50% of acute sporadic hepatitis in both children and adults in some high epidemic areas. Risk factors for infection among persons with sporadic cases of hepatitis E have not been defined.
<b>PREVENTION</b>	Immune globulin, or vaccination. Wash hands after using toilet. Clean surfaces contaminated with feces such as infant changing tables.	Vaccination and safe sex, clean up infected blood with bleach and wear protective gloves. Avoid sharing razors and toothbrushes.	Safe sex. Clean up spilled blood with bleach. Wear gloves when touching blood. Avoid sharing razors or toothbrushes.	Haptititus B vaccine to prevent infection. Safe sex.	Avoid drinking or using contaminated water. Avoiding drinking water (and beverages with ice) of unknown purity, uncooked shellfish, and uncooked fruits or vegetables that are not peeled or prepared by traveler. IG prepared from plasma collected in non-HEV-endemic areas is not effective in preventing clinical disease during hepatitis E outbreaks and the efficacy of IG prepared from plasma collected in HEV-endemic areas is unclear.



# SEVERE ACUTE RESPIRATORY SYNDROME

## GUIDELINES AND RECOMMENDATIONS

### Interim Domestic Guidance for Health Departments in the Management of School Students Exposed to Severe Acute Respiratory Syndrome (SARS)

*Severe acute respiratory syndrome (SARS) is a respiratory illness caused by a novel coronavirus, called SARS-associated coronavirus (SARS-CoV). The disease was first recognized in Asia in February 2003, and over the next several months spread to more than two dozen countries in North and South America, Europe, and Asia. In July, cases were no longer being reported, and SARS outbreaks worldwide were considered contained. Additional information about the SARS pandemic is available on the World Health Organization's (WHO) SARS Web site ([www.who.int/csr/sars/en/](http://www.who.int/csr/sars/en/)) and the Centers for Disease Control and Prevention's (CDC) SARS Web site ([www.cdc.gov/ncidod/sars/](http://www.cdc.gov/ncidod/sars/)).*

*CDC is working with domestic and international partners to prepare for the possible re-emergence of SARS. This interim guidance document was developed during the SARS outbreak of February-July 2003 and will be revised as additional information becomes available.*

Most patients with SARS, see ([www.cdc.gov/ncidod/sars/factsheet.htm](http://www.cdc.gov/ncidod/sars/factsheet.htm)) in the United States were exposed through foreign travel to countries with community transmission of SARS (areas with community transmission can be found at the case definition page at [[www.cdc.gov/ncidod/sars/casedefinition.htm](http://www.cdc.gov/ncidod/sars/casedefinition.htm)]), with only limited secondary spread to close contacts such as family members and health-care workers. Casual contact with a SARS patient at schools, other institutions, or public gatherings (e.g., attending the same class or public gathering) has not resulted in documented transmission in the United States. However, management of students exposed (i.e., through foreign travel or close contact) to SARS patients is a concern. The following are interim recommendations to assist health departments in the management of exposed students.

1. Students who may have been exposed to SARS should be vigilant for fever (i.e. measure temperature twice daily) and respiratory symptoms over the 10 days following exposure.\* During this time, in the absence of both fever and respiratory symptoms, students need not limit their activities outside the home and should not be excluded from school, or other public areas. However, the exposure should be reported to the appropriate points of contact (e.g., school officials and local health authorities).
2. Exposed students should notify school officials and their health-care provider immediately if fever OR respiratory symptoms develop. **In advance of clinical evaluation health-care providers should be informed that the student may have been exposed to SARS so arrangements can be made, as necessary, to prevent transmission to others in the health-care setting.**
3. Symptomatic students exposed to SARS should follow the following infection control precautions:
  - If fever OR respiratory symptoms develop, the student should not go to school or work, but should stay home while arranging health-care evaluation. In addition, the student should use infection control precautions ([www.cdc.gov/ncidod/sars/ic-closecontacts.htm](http://www.cdc.gov/ncidod/sars/ic-closecontacts.htm)) in the home to minimize the risk for transmission, and continue to measure temperature twice daily.

August 18, 2003

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## **Interim Domestic Guidance for Health Departments in the Management of School Students Exposed to Severe Acute Respiratory Syndrome (SARS)**

(continued from previous page)

- If a symptomatic exposed student lives in a residence where appropriate infection control precautions cannot be implemented and maintained (e.g., crowded dormitory setting), alternative housing arrangements should be made. If there is no such alternative, the student should be hospitalized, or housed in a designated residential facility for convalescing SARS patients, where infection control precautions can be followed.
- If symptoms improve or resolve within 72 hours after first symptom onset, the student may be allowed after consultation with local public health authorities to return to school or work and infection control precautions can be discontinued (see figure below).
- For students who meet or progress to meet the case definition for suspected SARS (e.g., develop fever and respiratory symptoms), infection control precautions should be continued until 10 days after the resolution of fever, provided respiratory symptoms are absent or improving.
- If the illness does not progress to meet the case definition, but the student has persistent fever\*\* or un-resolving respiratory symptoms, infection control precautions should be continued for an additional 72 hours, at the end of which time a clinical evaluation should be performed. If the illness progresses to meet the case definition, infection control precautions should be continued as described above. If case definition criteria are not met, infection control precautions can be discontinued after consultation with local public health authorities and the evaluating clinician (see figure below). Factors that might be considered include the nature of the potential exposure to SARS, nature of contact with others in the residential or work setting, and evidence for an alternative diagnosis.

4. Students who meet or progress to meet the case definition for suspected SARS (e.g., develop fever and respiratory symptoms) or whose illness does not meet the case definition, but who have persistent fever or un-resolving respiratory symptoms over the 72 hours following onset of symptoms should be tested for SARS coronavirus infection. Collection of appropriate specimens for laboratory testing ([www.cdc.gov/ncidod/sars/specimen\\_collection\\_sars2.htm](http://www.cdc.gov/ncidod/sars/specimen_collection_sars2.htm)) should be coordinated with and guided by local/state public health authorities and consultation with CDC.

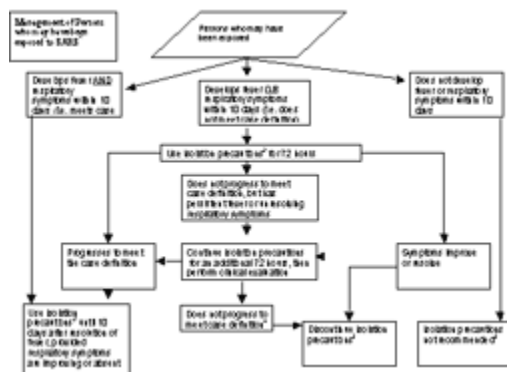
5. In a school that has a symptomatic exposed student in attendance during the 10 days following exposure, education concerning the symptoms of SARS and monitoring of potentially exposed students and school personnel should be conducted in consultation with the local health department.

\* Monitoring for signs and symptoms should be tailored to the specific school setting or age group. Some students may require assistance from parents or school officials in monitoring for signs of illness.

\*\*Clinical judgment should be used when evaluating patients for whom a measured temperature of  $>100.4^{\circ}\text{F}$  ( $>38^{\circ}\text{C}$ ) has not been documented. Factors that might be considered include patient self-report of fever, use of antipyretics, presence of immunocompromising conditions or therapies, lack of access to health care, or inability to obtain a measured temperature. Reporting authorities might consider these factors when determining whether infection control precautions should be continued.

## Interim Domestic Guidance for Health Departments in the Management of School Students Exposed to Severe Acute Respiratory Syndrome (SARS)

(continued from previous page)



<sup>1</sup>Exposure includes travel from areas with documented or suspected community transmission of SARS or close contact with persons who have SARS; close contact is defined as having cared for or lived with a person known to have SARS or having a high likelihood of direct contact with respiratory secretions and/or body fluids of a patient known to have SARS. Examples of close contact include kissing or embracing, sharing eating or drinking utensils, close conversation (<3 feet), physical examination, and any other direct physical contact between persons. Close contact does not include activities such as walking by a person or sitting across a waiting room or office for a brief period of time.

<sup>2</sup>Isolation precautions include limiting patient's interactions with others outside the home (e.g., should not go to work, school, out of home day care, church or other public areas), and following infection control guidelines for the home or residential setting if not admitted to hospital for care.

<sup>3</sup>Persons need not limit interactions outside of home (e.g., need not be excluded from work, school, out of home day care, church or other public areas).

<sup>4</sup>Discontinuation of isolation precautions for patients who have not met the case definition 6 days following onset of symptoms, but who have persistent fever or respiratory symptoms, should be done only after consultation with local public health authorities and the evaluating clinician. Factors that might be considered include the nature of the potential exposure to SARS, nature of contact with others in the residential or work setting, and evidence for an alternative.

For more information, visit [www.cdc.gov/ncidod/sars](http://www.cdc.gov/ncidod/sars) or call the CDC public response hotline at (888) 246-2675 (English), (888) 246-2857 (Español), or (866) 874-2646 (TTY)



## TUBERCULOSIS QUESTIONNAIRE

Child's Name: \_\_\_\_\_  
 School Name: \_\_\_\_\_  
 Parent Signature: \_\_\_\_\_  
 Date: \_\_\_\_\_

This questionnaire is about tuberculosis. Tuberculosis can be transmitted to children by adults who live with or spend a great deal of time with them. Tuberculosis is transmitted by a person who has tuberculosis to another person through airborne droplets that are coughed or sneezed into the air and then breathed in by the child. This transmission of infection is more likely to occur when the child and the infectious person spend a lot of time together in a closed environment such as a car, a small room, or other similar situations.

Adults who have tuberculosis will often have the following symptoms: cough for more than two weeks duration, loss of appetite, weight loss of ten or more pounds over a short period of time, fever, chills and night sweats.

Children with tuberculosis frequently do not have symptoms. A person can have tuberculosis infection and not have active tuberculosis.

- **Not everyone who coughs has tuberculosis**
- **TB can cause (low grade) fever of long duration, unexplained weight loss, failure to maintain adequate growth in children, weakness, chest pain, a bad cough, hoarseness, and/or coughing up blood.**
- **Tuberculosis is preventable and treatable.**
- **Children with active TB often do not show signs of illness. Infants are more likely to have symptoms.**

Has the child had a TB test?

If yes, when?

If yes, what were the results?

\_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

	YES	NO
Has anyone in your family had tuberculosis?		
Do you know any situation where your child was around an adult who has been diagnosed or suspected of having TB?		

## TUBERCULOSIS QUESTIONNAIRE

	YES	NO
Has your child been around anyone who has fever of long duration unexplained weight loss, weakness, chest pain, a bad cough, hoarseness or coughing up blood?		
Has your child had any of the above problems?		
To your knowledge, has your child had close contact with anyone who:  has been in a homeless shelter?		
Is/has been in jail or prison?		
Is/has been an intravenous (IV) drug user?		
Is HIV infected?		
Has your child recently moved to the U.S. from a foreign country or traveled to a foreign country?		
If yes, what country?		
Is the child taking immunosuppressive drugs?		

## TUBERCULIN SKIN TEST (TST) RECOMMENDATIONS FOR INFANTS, CHILDREN, AND ADOLESCENTS\*

Children for whom immediate TST is indicated:

- Contacts of persons with confirmed or suspected infectious tuberculosis (contact investigation); this includes children identified as contacts of family members or associates in jail or prison during the last 5 years
- Children with radiographic or clinical findings suggesting tuberculosis disease
- Children immigrating from endemic countries (eg, Asia, Middle East, Africa, Latin America)
- Children with travel histories to endemic countries and/or significant contact with indigenous persons from such countries~

Children who should have annual TST<sup>†</sup>:

- Children infected with HIV or living in household with HIV-infected persons
- Incarcerated adolescents

Children who should be tested every 2-3 years<sup>†</sup>:

- Children exposed to the following persons: HIV-infected, homeless, residents of nursing homes, institutionalized adolescents or adults, users of illicit drugs, incarcerated adolescents or adults, and migrant farm workers; foster children with exposure to adults in the preceding high-risk groups are included

Children who should be considered for TST at 4-6 and 11-16 years of age:

- Children whose parents immigrated (with unknown TST status) from regions of the world with high prevalence of tuberculosis; continued potential exposure by travel to the endemic areas and/or household contact with persons from endemic areas (with unknown TST status) should be an indication for a repeated TST
- Children without specific risk-factors who reside in high-prevalence areas; in general, a high-risk neighborhood or community does not mean an entire city is at high risk; rates in any area in the city may vary by neighborhood or even from block to block; physicians should be aware of these patterns when determining the likelihood of exposure; public health officials or local tuberculosis experts should help physicians identify areas with appreciable tuberculosis rates

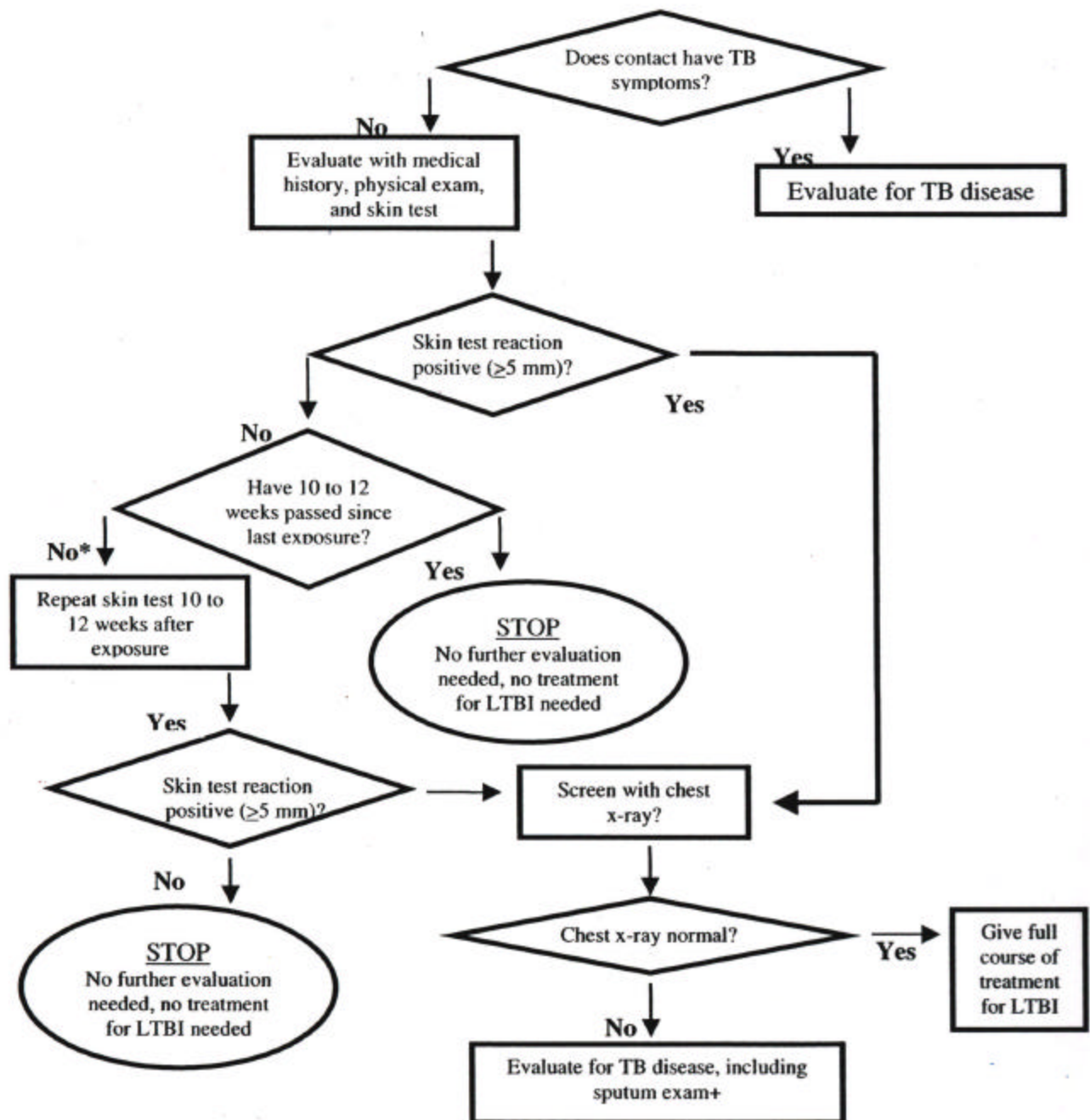
Children at increased risk for progression of infection to disease: Those with other medical conditions, including diabetes mellitus, chronic renal failure, malnutrition, and congenital or acquired immunodeficiencies deserve special consideration. Without recent exposure, these persons are not at increased risk of acquiring tuberculosis infection. Underlying immune deficiencies associated with these conditions theoretically would enhance the possibility for progression to severe disease. Initial histories of potential exposure to tuberculosis should be included for all of these patients. If these histories or local epidemiologic factors suggest a possibility of exposure, immediate and periodic TST should be considered. An initial TST should be performed before initiation of immunosuppressive therapy for any child with an underlying condition that necessitates immunosuppressive therapy.

\* Bacille Calmette-Guerin immunization is not a contraindication to TST. HIV indicates human immunodeficiency virus.

<sup>†</sup>Initial TST is at the time of diagnosis or circumstance, beginning at 3 months of age.

Reference: 2000 Red Book-Report of the Committee on Infectious Diseases (25th Edition)

## TESTING, TREATMENT, AND FOLLOW-UP FOR CONTACTS 4 YEARS OF AGE OR OLDER



\* High-risk close contacts with a negative reaction may be evaluated for and start LTBI at this point if there is evidence of recent transmission to other contacts (e.g., many other contacts have a positive reaction). If repeat skin test is negative, stop treatment for LTBI.

+ Some children may be unable to give an adequate sputum specimen. If warranted, a gastric aspirate should be obtained.

Figure 6.8 Testing, treatment, and follow-up for contacts 4 years of age or older.

## TESTING, TREATMENT, AND FOLLOW-UP FOR CONTACTS UNDER 4 YEARS OF AGE

